

## Cómo presentar un reclamo con el Fondo de Empleadores Sin Seguro

La ley de California obliga a todos los empleadores a tener un seguro de compensación de trabajadores. Los empleadores pueden obtener un seguro de una compañía de seguros o pueden ser autoasegurados por medio de un programa estatal. Aun cuando su empleador no tenga un seguro de compensación válido cuando usted se lesiona, usted tiene el derecho a tratamiento médico y otros beneficios. El Fondo estatal de Empleadores Sin Seguro (UEF) es un fondo especial usado para pagar reclamos de empleados que se lastiman o se enferman mientras trabajan para un empleador que está ilegalmente sin seguro. Sin embargo, los beneficios no son pagados automáticamente.

Tiene que tomar los pasos abajo descritos para proceder con un reclamo para beneficios del UEF. Necesita un paquete de información y formularios que puede obtener de su oficial de Información y Asistencia (I&A) de la División de Compensación de Trabajadores (DWC) local. Este paquete incluye la hoja de información F de la DWC, las guías 16 (A) y 16 (B) de I&A y otros formularios.

Este proceso puede parecer difícil, pero tomando las cosas paso a paso, ayudará. Tal vez, querrá consultar con un abogado de su propia elección.

Siga estos 11 pasos en orden y no omita ninguno. Es muy importante mantener buena documentación, incluyendo notas de con quién tiene contacto.

1. Llene la sección del empleado del formulario de reclamo de compensación de trabajadores. Ésta se llama la "DWC-1, Petición del Empleado Para Beneficios de Compensación de Trabajadores." Vea la guía de I&A 1 para asistencia. Guarde una copia de este formulario para su propia documentación. Éste es su recibo temporal. Usted puede entregarsela personalmente a su empleador o le puede mandar tres copias por correo certificado con acuse de recibo. Si envía los formularios por correo, guarde una copia del acuse de recibo para su propia documentación. Si los entrega personalmente, haga nota de cuando y a quién se los entregó.
2. Llene el formulario "Servicio de Búsqueda de Cobertura" de su paquete y envíelo a:

Workers' Compensation Insurance Rating Bureau (WCIRB)  
Customer Service, ATTN: Coverage Department  
525 Market Street Ste 800  
San Francisco, CA 94105

La WCIRB determinará si su empleador tenía un seguro de compensación de trabajadores cuando usted se lesionó. La WCIRB puede usar el nombre del negocio de su empleador, el nombre del dueño y dirección(es) para verificar cobertura, por lo tanto llene el formulario lo más que pueda. La WCIRB generalmente no les cobra a los trabajadores lesionados su cuota de \$8. Tiene que recibir una respuesta de la WCIRB por correo. Guardela para su documentación.

3. Mientras espera la respuesta de la WCIRB, reúna la siguiente información para respaldar su reclamo:
  - Informes médicos de su médico para documentar su lesión de trabajo
  - Cobros médicos por su lesión, incluyendo recibos por cosas que haya pagado (prescripciones, visitas médicas, etc...)
  - Verificación de empleo, como talones de cheques y formularios W-2 de alrededor de la fecha en que se lesionó. Ésto ayudará a calcular los beneficios que pueda recibir y demostrará que trabajó para el empleador
  - Haga una lista de posibles testigos de su lesión

4. Si la respuesta de la WCIRB demuestra que su empleador no tenía un seguro de compensación de trabajadores cuando usted se lesionó y usted quiere proceder con un reclamo con el UEF, tiene que presentar varios formularios con su oficina local de la Junta de Apelaciones de Compensación de Trabajadores (WCAB). Llene una solicitud para adjudicación del reclamo (Vea la guía 4 de I&A). Lea, firme y ponga la fecha en la declaración conforme al Código Laboral 4906 (g) contenida en la guía 4. Presente la solicitud para adjudicación del reclamo para , la 4906 (g) y el formulario de prueba de entrega por correo (también contenida en la guía 4) con su oficina local de la WCAB. Las direcciones de las oficinas están en su paquete. Tiene que demostrar que envió por correo una copia de estos formularios a su empleador usando el formulario de prueba de entrega por correo.

El presentar estos formularios abre un caso para usted en la WCAB. Le permite a la WCAB ayudarle a resolver su reclamo. Tiene que recibir una noticia de la WCAB por correo de que una solicitud para adjudicación del reclamo fue presentada con su número de caso indicado.

5. También debe de llenar los siguientes formularios de su paquete:
  - Declaración de disposición para proceder (Vea la guía 5 de I&A). Este formulario es su solicitud para una conferencia con la WCAB para ayudarle a resolver su reclamo
  - La Noticia especial de demanda. Este formulario notifica a su empleador que una acción legal está siendo tomada contra él. Su empleador tiene que ser denominado correctamente y el reclamo tiene que ser presentado o entregado personalmente. Vea la guía 16 (A) de I&A para más información sobre cómo denominar a su empleador. Vea la guía 16 (B) de I&A para más información sobre cómo presentarle o entregarle personalmente el reclamo del UEF a su empleador
  - Petición para unir a un partido demandado. Este formulario le pide a un juez que formalmente haga un reclamo de su caso o sea que lo "una" con el Fondo de Empleadores Sin Seguro.
6. Tan pronto tenga su documentación y haya llenado todos los formularios, ponga los documentos originales en un paquete en el siguiente orden (de arriba abajo) para entregárselos a su empleador:
  - a. Noticia especial de demanda
  - b. Declaración de disposición para proceder
  - c. DWC-1, Petición del Empleado Para Beneficios de Compensación de Trabajadores o formulario de reclamo, y acuse de recibo del correo registrado
  - d. Informes médicos
  - e. Cobros médicos
  - f. Verificación de empleo
  - g. La respuesta de la WCIRB indicando que su empleador no tenía cobertura de seguro de compensación de trabajadores
  - h. Petición para unir a un partido demandado
7. Este será el paquete "original". Haga tres (3) copias de este paquete. Si su empleador es un consorcio, haga copias adicionales para cada socio.
8. Una copia de este paquete tiene que ser personalmente entregado a su empleador por medio de un servicio de entrega personal. Vea la guía 16(B) de I&A para información sobre cómo presentarle a su empleador el reclamo. Un formulario de prueba de entrega personal está incluido en su paquete. **Nota:** La prueba de entrega personal es diferente a la prueba de entrega por correo hecha previamente. Para asegurarse que el servicio de entrega personal es hecho correctamente, tiene que usar un servicio profesional como el departamento local del alguacil (sheriff) o una compañía de portadores de citaciones. Si usa este método recibirá un comprobante que la entrega fue hecha o intentada tres veces con su empleador.
9. Después de que la prueba de entrega es regresada, presente el paquete "original" a la oficina de la WCAB cercana a usted. Si casi es un año puesto que se haya lesionado y todavía no ha presentado un reclamo, pongase en contacto inmediatamente con la oficina de I&A cercana a usted para asistencia. Vea la lista de direcciones de las oficinas de la WCAB que encontrará en su paquete.

10. Mientras no esté obligado a hacerlo, el UEF puede decidir pagar sus beneficios antes de que un juez de compensación de trabajadores haga un "fallo" en su caso. Para solicitar beneficios del UEF, envíe una carta pidiendo beneficios y una copia del paquete a la oficina del UEF cercana a usted:

UEF claims

1515 Clay Street, 17<sup>th</sup> floor

**OAKLAND** CA 94612

UEF claims

320 W. 4<sup>th</sup> Street, 6<sup>th</sup> floor

**LOS ANGELES** CA 90013

UEF claims

2424 Arden Way, #355

**SACRAMENTO** CA 95825

11. Guarde una copia del paquete para sus archivos. Tiene que recibir una noticia de conferencia de la WCAB dentro de unas semanas. Digale a su oficial de I&A local si es que el UEF empieza a pagarle beneficios antes de que un juez de compensación de trabajadores haga un "fallo" en su caso.

También puede presentar una queja contra su empleador por no haber tenido un seguro de compensación de trabajadores. Pongase en contacto con la División para el Cumplimiento de las Normas Laborales, Oficina de Investigaciones. Puede encontrarlos en la sección del gobierno estatal del directorio telefónico, Relaciones Industriales, División para el Cumplimiento de las Normas Laborales. También puede obtener en línea el formulario para presentar una queja en la página Web en [www.dir.ca.gov/dlse](http://www.dir.ca.gov/dlse). La Oficina de Investigaciones puede pedir que una copia de la respuesta de la WCIRB indicando que su empleador no tenía seguro de compensación de trabajadores sea sometida con el formulario de queja. La oficina de Investigaciones puede multar y en algunos casos cerrar empleadores ilegalmente sin seguro.

Si necesita ayuda llame a la oficina de Información y Asistencia (I&A) o asista a un taller para trabajadores lesionados. Los números de teléfono de la oficina local de I&A están adjunto. Puede obtener información sobre un taller local de la oficina de I&A o en la página Web en [www.dir.ca.gov/dwc](http://www.dir.ca.gov/dwc).

La información contenida en esta hoja de información es de índole general y no está intencionada a substituir asesoramiento legal. Cambios en la ley o los datos específicos de su caso pueden resultar en interpretaciones legales diferentes a las que estén presentadas aquí.

## DIVISION OF WORKERS' COMPENSATION DISTRICT OFFICES

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**ANAHEIM, 92801-1162**

1661 N. Raymond Ave., Suite 202  
Information & Assistance Unit (714) 738-4038

**BAKERSFIELD, 93301-1929**

1800 30<sup>th</sup> Street, Suite 100  
Information & Assistance Unit (661) 395-2514

**EUREKA, 95501-0481**

100 "H" Street, Suite 202  
Information & Assistance Unit (707) 441-5723

**FRESNO, 93721-2280**

2550 Mariposa Street, Suite 4078  
Information & Assistance Unit (559) 445-5355

**GOLETA, 93117-3018**

6755 Hollister Avenue, Suite 100  
Information & Assistance Unit (805) 968-4158

**GROVER BEACH, 93433-2261**

1562 W. Grand Avenue  
Information & Assistance Unit (805) 481-3380

**LONG BEACH, 90802-4339**

300 Oceangate Streets, Suite 200  
Information & Assistance Unit (562) 590-5240

**LOS ANGELES, 90013-1105**

320 West 4<sup>th</sup> Street, 9<sup>th</sup> Floor  
Information & Assistance Unit (213) 576-7389

**MARINA DEL REY, CA 90292**

4720 Lincoln Blvd. 2<sup>nd</sup> floor  
Information & Assistance Unit (310) 482-3858

**OAKLAND, 94612-1402**

1515 Clay Street, 6<sup>th</sup> Floor  
Information & Assistance Unit (510) 622-2861

**OXNARD, 93030**

2220 East Gonzales Road, Suite 100  
Information & Assistance Unit (805) 485-3528

**POMONA, 91766-1601**

732 Corporate Center Drive  
Information & Assistance Unit (909) 623-8568

**REDDING, 96001-2796**

2115 Civic Center Drive, Suite 15  
Information & Assistance Unit (530) 225-2047

**RIVERSIDE, 92501-3337**

3737 Main Street, Suite 300  
Information & Assistance Unit (951) 782-4347

**SACRAMENTO, 95825-2403**

2424 Arden Way, Suite 230  
Information & Assistance Unit (916) 263-2741

**SALINAS, 93906-2204**

1880 North Main Street, Suites 100 & 200  
Information & Assistance (831) 443-3058

**SAN BERNARDINO, 92401-1411**

464 West Fourth Street, Suite 239  
Information & Assistance Unit (909) 383-4522

**SAN DIEGO, 92108**

7575 Metropolitan Drive, Suite 202  
Information & Assistance Unit (619) 767-2170

**SAN FRANCISCO, 94102-7002**

455 Golden Gate Avenue, 2<sup>nd</sup> Floor  
Information & Assistance Unit (415) 703-5020

**SAN JOSE, 95113-1482**

100 Paseo de San Antonio, Suite 241  
Information & Assistance Unit (408) 277-1292

**SANTA ANA, 92701-4070**

28 Civic Center Plaza, Suite 451  
Information & Assistance Unit (714) 558-4597

**SANTA ROSA, 95404-4760**

50 "D" Streets, Suite 420  
Information & Assistance Unit (707) 576-2452

**STOCKTON, 94202**

31 East Channel Street, Suite 344  
Information & Assistance Unit (209) 948-7980

**VAN NUYS, 91401-3373**

6150 Van Nuys Blvd., Suite 105  
Information & Assistance Unit (818) 901-5374

## Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

### Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

**Medical Care:** Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

**The Primary Treating Physician (PTP)** is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your pre-designated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

**Disclosure of Medical Records:** After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

**Payment for Temporary Disability (Lost Wages):** If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

**Atención Médica:** Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

**El Médico Primario que le Atiende-Primary Treating Physician PTP** es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al PTP que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o después de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento aplicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares (\$10,000).

**Divulgación de Expedientes Médicos:** Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la juez "selle" (mantenga privados) ciertos expedientes médicos.

**Pago por Incapacidad Temporal (Sueldos Perdidos):** Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de

## Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

### Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



**Return to Work:** To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

**Payment for Permanent Disability:** If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

**Vocational Rehabilitation (VR):** If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

**Supplemental Job Displacement Benefit (SJDB):** If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

**Death Benefits:** If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

**It is illegal for your employer** to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to the DWC web site at [www.dir.ca.gov](http://www.dir.ca.gov). Link to Workers' Compensation.

**You can consult with an attorney.** Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at [www.californiaspecialist.org](http://www.californiaspecialist.org).

impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de noche, o no pueda trabajar durante más de 14 días.

**Regreso al Trabajo:** Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atiende, el/la administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

**Pago por Incapacidad Permanente:** Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

**Rehabilitación Vocacional:** Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

**Beneficio Suplementario por Desplazamiento de Trabajo:** Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapacidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitos, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapacidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

**Beneficios por Muerte:** Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

**Es ilegal que su empleador** le castigue o despidan, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Código Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador (*Division of Workers' Compensation - DWC*), o puede escuchar información grabada, así como una lista de oficinas locales, llamando al (800) 736-7401. Ud. también puede ir al sitio electrónico en el Internet de la DWC en [www.dir.ca.gov](http://www.dir.ca.gov). Enlázese a la sección de Compensación para Trabajadores.

**Ud. puede consultar con un(a) abogado(a).** La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California (*State Bar*) al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en [www.californiaspecialist.org](http://www.californiaspecialist.org).



**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

**PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)**

**Employee:** Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**Empleado:** Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

**Employee—complete this section and see note above      Empleado—complete esta sección y note la notación arriba.**

1. Name. *Nombre.* \_\_\_\_\_ Today's Date. *Fecha de Hoy.* \_\_\_\_\_
2. Home Address. *Dirección Residencial.* \_\_\_\_\_
3. City. *Ciudad.* \_\_\_\_\_ State. *Estado.* \_\_\_\_\_ Zip. *Código Postal.* \_\_\_\_\_
4. Date of Injury. *Fecha de la lesión (accidente).* \_\_\_\_\_ Time of Injury. *Hora en que ocurrió.* \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* \_\_\_\_\_  
\_\_\_\_\_
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* \_\_\_\_\_  
\_\_\_\_\_
7. Social Security Number. *Número de Seguro Social del Empleado.* \_\_\_\_\_
8. Signature of employee. *Firma del empleado.* \_\_\_\_\_

**Employer—complete this section and see note below.      Empleador—complete esta sección y note la notación abajo.**

9. Name of employer. *Nombre del empleador.* \_\_\_\_\_
10. Address. *Dirección.* \_\_\_\_\_
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* \_\_\_\_\_
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_  
\_\_\_\_\_
15. Insurance Policy Number. *El número de la póliza de Seguro.* \_\_\_\_\_
16. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
17. Title. *Título.* \_\_\_\_\_ 18. Telephone. *Teléfono.* \_\_\_\_\_

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Employer copy/Copia del Empleador       Employee copy/ Copia del Empleado

**Empleador:** Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Claims Administrator/Administrador de Reclamos       Temporary Receipt/Recibo del Empleado

# Coverage Research Service Request Form 807

## Instructions

### Who Can Use the Coverage Research Service

The WCIRB can provide coverage information to an insurance company, employer, injured worker, licensed health care provider, Third Party Entity (TPE) acting on behalf of a member insurer who has a TPE agreement with the WCIRB, or an attorney involved in a pending workers' compensation claim. Before the coverage request will be processed, the requesting party must certify that he/she is entitled to receive the information, that the information will be used solely in connection with the pending workers' compensation claim, and that the information will not be otherwise published, distributed, or released to third parties other than in connection with the administration and/or litigation of the pending workers' compensation claim. Employers or insurers may have access to their own information even if there is no pending workers' compensation claim.

### Requirements

Completion of the Coverage Research Service Request Form is required for coverage requests made in connection with a pending workers' compensation claim.

The WCIRB will not process your coverage research service request unless all five sections of the form are completely filled out. The requesting party must provide the WCIRB with necessary information regarding the pending workers' compensation claim for which the information is sought, including the name of the parties, date of injury, claim number (if known), and WCAB number (if assigned). Incomplete information will delay the completion of your request.

### Form Completion

- Please print or type
- This form can be completed electronically but requires a signature and must be mailed to the WCIRB
- Please complete all necessary information on page 1 and page 2
- If you need additional information, please call WCIRB Customer Service

### To Request Coverage Research

**Mail** WCIRB Customer Service  
Attn: Coverage Department  
525 Market Street, Suite 800  
San Francisco, CA 94105-2767

### Fees

The fee for coverage research is **\$8.00 per coverage year per employer**. For example, the fee for a research request for one employer for one year is \$8.00. The fee for a research request for one employer for policy years 1998-1999 is \$16.00. The fee for a research request for ABC Corp., XYZ Corp. and OPQ Corp. for the 2001 policy year is \$24.00.

### Payment

Payment must be received before your request can be processed.

WCIRB member insurers may elect to be billed.

TPEs, authorized by WCIRB member insurers, may elect to have the WCIRB bill the member insurer. The WCIRB is unable to bill TPEs directly.

For all others, the WCIRB accepts payment by check only. Please include your payment when submitting the Coverage Research Service Request Form.

### Shipping

**Mail** Coverage research requests will be mailed.

**Email** If you want to receive the information by email, please be sure to check the designated box on the order form.

### Questions

Call our Customer Service Department toll free 888.CA WCIRB (229.2472) 7:30 a.m.–5:00 p.m. PST.

**WCIRB**California™

**WCIRB Customer Service**  
**ATTN: Coverage Department**  
525 Market Street, Suite 800  
San Francisco, CA 94105-2767  
Voice 888.229.2472  
customerservice@wcirbonline.org  
www.wcirbonline.org

# Coverage Research Service Request

**Form 807** **Electronic Form**

**Signature required. This form must be mailed.**

---

## Pending Workers' Compensation Claim Information

Injured Worker	Date of Injury
Employer	WCAB Number (if assigned)
Insurer (if known)	Claim Number (if known)

---

## Requesting Party Information

Print Name of Individual Requesting Information	Title/Position
Company OR Injured Worker Represented	Telephone
Address (If Injured Worker, Include Your Own Address)	If an Attorney, Indicate Party Represented
City/State/Zip	Email Address (Required for Email Delivery)

---

## Certification

The requesting individual hereby certifies that he/she is:

- the injured worker in the pending workers' compensation claim; **OR**
  - an employee, partner, manager, officer, director, or owner of, and has the authority to bind:
- a licensed workers' compensation insurance insurer in the pending workers' compensation claim;
- an employer, as defined by Labor Code Section 3300, in the pending workers' compensation claim;
- a licensed health care provider in the pending workers' compensation claim;
- a Third Party Entity (TPE) that is authorized by a member insurer to obtain coverage information;

**; OR**

TPE Name	Member Insurer Name
----------	---------------------

an attorney representing any of the above individuals or entities in the pending workers' compensation claim.

---

## Coverage Information Requested

For additional employers, attach a separate sheet. The WCIRB is unable to supply coverage information prior to 1958.

(1)	(2)
Employer	Employer
Address	Address
City/State/Zip Code	City/State/Zip Code
Coverage Year(s) Requested	Coverage Year(s) Requested

# Coverage Research Service Request

## Form 807

**Signature required. This form must be mailed.**

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### Restricted Use of Information

I agree that the coverage information provided shall be used solely in connection with the administration and/or litigation of the above-referenced pending workers' compensation claim, and for no other purpose. In addition, I agree that the information provided by the WCIRB is confidential and proprietary and shall not be published, distributed, released or communicated to third parties, other than in relation to the administration and/or litigation of the above-referenced pending workers' compensation claim. I affirm that all information provided on this form is true and correct.

---

Signature \_\_\_\_\_

Date \_\_\_\_\_

---

### Delivery

Check this box for email delivery.

---

### Payment (See instructions.)

The WCIRB accepts payment by check only.  
Please make your check payable to "WCIRB" and mail to the address on this form.

Fee enclosed (nonrefundable) \$ \_\_\_\_\_

Bill My Company

**(WCIRB member insurers and authorized TPEs only. See instructions.)**

2 of 2

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WCIRB Customer Service  
Attn: Coverage Department

525 Market Street, Suite 800  
San Francisco, CA 94105-2767

Voice 888.229.2472  
Fax 415.778.7272

customerservice@wcirbonline.org  
www.wcirbonline.org

## WORKERS' COMPENSATION APPEALS BOARD

### APPLICATION FOR ADJUDICATION OF CLAIM (PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. (Deje este espacio en blanco)

M Su nombre

Su domicilio completo  
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No. Su número de seguro social

\_\_\_\_\_

(Deje este espacio en blanco)  
(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)  
VS.

(Deje este espacio en blanco)  
(APPLICANT'S ADDRESS AND ZIP CODE)

Nombre del empleador  
(EMPLOYER--STATE IF SELF INSURED)

Dirección del empleador  
(EMPLOYER'S ADDRESS AND ZIP CODE)

Nombre de la compañía de seguros del empleador  
(EMPLOYER'S INSURANCE CARRIER OR, IF SELF INSURED, ADJUSTING AGENCY.)

Dirección de la compañía de seguros del empleador  
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

### IT IS CLAIMED THAT:

Su fecha de

1. The injured employee, born nacimiento, while employed as Su ocupación al tiempo del accidente  
(DATE OF BIRTH) (OCCUPATION AT THE TIME OF INJURY)

on Fecha del accidente at Dirección donde ocurrió el accidente  
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)

by the employer, sustained injury arising out of and in the course of employment to:

Indique las partes del cuerpo que se lesionó  
(STATE WHICH PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: Indique lo que estaba haciendo cuando se lesionó  
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at the time of injury were: El salario semanal o mensual y horas que trabaja por semana. Declare el valor de todas sus ganancias incluyendo propinas  
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)  
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: La fecha del último día que trabajó por causa del accidente  
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid (YES) (NO) \$ (TOTAL PAID) \$ (WEEKLY RATE) La fecha del último pago hecho por la compañía de seguros  
(DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury (YES) (NO)

7. Medical treatment was received (YES) (NO) La fecha de la última cita con el All treatment was furnished by the Employer or Insurance Company (YES) (NO) Other treatment was provided paid by: Indique el nombre de la persona o agencia incluyendo seguro privado médico que haya pagado por su tratamiento médico Did Medi-Cal pay for any health care (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

related to this claim? (YES) (NO) doctors not provided or paid for by employer or insurance company who treated or examined

for this injury are Indique el nombre y dirección del médico o hospital que no haya sido pagado por la compañía de seguros  
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: Indique si tiene otros casos de lesiones de trabajo, Ponga el número de caso y fecha de lesión  
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity \_\_\_\_\_

Permanent disability indemnity \_\_\_\_\_ Reimbursement for medical expense \_\_\_\_\_ Medical treatment \_\_\_\_\_

Compensation at proper rate \_\_\_\_\_ Rehabilitation \_\_\_\_\_ Other (Specify) \_\_\_\_\_  
AND APPLICANT REQUESTS A HEARING AND

AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at Ciudad,  
(CITY)

California Fecha de hoy  
(DATE)

Su firma

(APPLICANT'S ATTORNEY)

(APPLICANT'S SIGNATURE)

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE  
FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM  
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. \_\_\_\_\_

M \_\_\_\_\_

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: \_\_\_\_\_

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE  
VS.

(APPLICANT'S ADDRESS AND ZIP CODE)

(EMPLOYER--STATE IF SELF-INSURED)

(EMPLOYER'S ADDRESS AND ZIP CODE)

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born \_\_\_\_\_ (DATE OF BIRTH), while employed as a \_\_\_\_\_ (OCCUPATION AT TIME OF INJURY)  
on \_\_\_\_\_ (DATE OF INJURY) at \_\_\_\_\_ (ADDRESS) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP CODE)  
By the employer sustained injury arising out of and in the course of employment to

(STATE WHAT PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: \_\_\_\_\_ (EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: \_\_\_\_\_ (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: \_\_\_\_\_ (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid \_\_\_\_\_ (YES) \_\_\_\_\_ (NO) \$ \_\_\_\_\_ (TOTAL PAID) \$ \_\_\_\_\_ (WEEKLY RATE) \_\_\_\_\_ (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury  
\_\_\_\_\_ (YES) \_\_\_\_\_ (NO)

7. Medical treatment was received \_\_\_\_\_ (YES) \_\_\_\_\_ (NO) \_\_\_\_\_ (DATE OF LAST TREATMENT) All treatment was furnished by  
the Employer or Insurance Company \_\_\_\_\_ (YES) \_\_\_\_\_ (NO) Other treatment was provided or paid by \_\_\_\_\_

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care

related to this claim \_\_\_\_\_ (YES) \_\_\_\_\_ (NO) doctors not provided or paid for by employer or insurance company who treated or examined  
for this injury are \_\_\_\_\_

(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: \_\_\_\_\_

(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity \_\_\_\_\_  
Permanent disability indemnity \_\_\_\_\_ Reimbursement for medical expense \_\_\_\_\_ Medical treatment \_\_\_\_\_  
Compensation at proper rate \_\_\_\_\_ Rehabilitation \_\_\_\_\_ Other (Specify) \_\_\_\_\_  
AND APPLICANT REQUESTS A HEARING AND

AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at \_\_\_\_\_ (CITY), California \_\_\_\_\_ (DATE)

(APPLICANT'S ATTORNEY)

(APPLICANT'S SIGNATURE)

(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

# EJEMPLO

## STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

Su nombre

*Applicant*

vs.

Nombre del empleador y  
Nombre de la compañía de seguros

*Defendants*

Case No. Número de caso

### DECLARATION OF READINESS TO PROCEED

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within **ten (10) days** after service of the Declaration. (Rule 10416)

The  Employee or Applicant  
 Defendant  
 Lien Claimant

requests that this case be set for hearing at Oficina de la WCAB donde quiere tener la audiencia  
(Place)

and Declarant states under penalty of perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following efforts to resolve these issues: Declare los esfuerzos que ha hecho para resolver el problema

Indique la clase de audiencia que quiere pedir

Declarant requests:  Mandatory Settlement Conference  Status Conference  Rating MSC\*  Priority Conference (L.C. §5502(c))

At the present time the principal issues are: Indique lo que está en disputa

Compensation Rate  Rehabilitation  
 Temporary Disability  Self-procured Treatment  
 Permanent Disability  Future Medical Treatment  
 Other \_\_\_\_\_

Declarant relies on the report(s) of Doctor(s) Nombre del médico que escribió el informe que está usando para respaldar su argumento dated Fecha del informe médico

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by WCAB Rules of Practice and Procedure.

Copies of this Declaration have been served this date as shown below.

Declarant's Signature Su firma

Name and Law Firm (Print or Type) Escriba su nombre en letra de molde

Address Su domicilio Phone Su número de teléfono

Date Fecha de hoy

### SERVICE

Names and addresses of parties, including law firms and representatives, and lien claimants served with a copy of this Declaration.

1. WCAB

2. Compañía de seguros

3. Abogado de la ompañía de seguros

\*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

**(SEE REVERSE SIDE FOR INSTRUCTIONS)**

**STATE OF CALIFORNIA  
WORKERS' COMPENSATION APPEALS BOARD**

	<i>Applicant</i>
vs.	
	<i>Defendants</i>

Case No. \_\_\_\_\_

**DECLARATION OF READINESS  
TO PROCEED**

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within <b>ten (10) days</b> after service of the Declaration. (Rule 10416)
--

The  Employee or Applicant  
 Defendant requests that this case be set for hearing at \_\_\_\_\_  
 Lien Claimant (Place)

and Declarant states under penalty of perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following efforts to resolve these issues: \_\_\_\_\_

\_\_\_\_\_

Declarant requests:  Mandatory Settlement Conference  Status Conference  Rating MSC\*  Priority Conference  
(L.C. §5502(c))

At the present time the principal issues are:

- |   |   |
|---|---|
| <input type="checkbox"/> Compensation Rate    | <input type="checkbox"/> Rehabilitation           |
| <input type="checkbox"/> Temporary Disability | <input type="checkbox"/> Self-procured Treatment  |
| <input type="checkbox"/> Permanent Disability | <input type="checkbox"/> Future Medical Treatment |
| <input type="checkbox"/> Other _____          |   |

Declarant relies on the report(s) of Doctor(s) \_\_\_\_\_ dated \_\_\_\_\_

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by WCAB Rules of Practice and Procedure.

Copies of this Declaration have been served this date as shown below.

Declarant's Signature \_\_\_\_\_

Name and Law Firm (Print or Type) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date \_\_\_\_\_

**SERVICE**

Names and addresses of parties, including law firms and representatives, and lien claimants served with a copy of this Declaration.

_____	_____
_____	_____
_____	_____

\*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

**(SEE REVERSE SIDE FOR INSTRUCTIONS)**

## Workers' Compensation Appeals Board Special Notice of Lawsuit

(Pursuant to Labor Code Section 3716 and Code of Civil Procedure Section 412.20)

WCAB No. \_\_\_\_\_

To: DEFENDANT, ILLEGALLY UNINSURED EMPLOYER:

AVISO: A ud le estan demandando. Le corte puede expedir una decision que le afecte sin que se le escuche a menos que ad actue pronto. Lea la siguiente informacion.

DEFENDANT:

APPLICANT:

--	--

### NOTICES

1. A lawsuit, the attached Application for Adjudication of Claim, has been filed with the Workers' Compensation Appeals Board against you as the named defendant by the above-named applicant(s).  
  
You may seek the advice of an attorney in any matter connected with this lawsuit and such attorney should be consulted promptly so that your response may be filed and entered in a timely fashion.  
  
If you do not know an attorney, you may call an attorney reference service or a legal aid office (see telephone directory).  
  
You may also request assistance/information from an Information and Assistant Office of the Division of Workers' Compensation (see telephone directory).
2. An Answer to the Application must be filed and served within six days of the service of the Application pursuant to Appeals Board rules; therefore, your written response must be filed with the Appeals Board promptly; a letter or phone call will not protect your interests.
3. You will be served with a Notice(s) of Hearing and must appear at all hearings or conferences. After such hearing, even absent your appearance, a decision may be made and an award of compensation benefits may issue against you. The award could result in the garnishment of your wages, taking of your money or property or other relief.  
  
If the Appeals Board makes an award against you, your house or other dwelling or other property may be taken to satisfy that award in a non-judicial sale, with no exemptions from execution.  
  
A lien may also be imposed upon your property without further hearing and before the issuance of an award.
4. You must notify the Appeals Board of the proper address for the service of official notices and papers and notify the Appeals Board of any changes in that address.

### TAKE ACTION NOW TO PROTECT YOUR INTERESTS!

**Issued by: WORKERS' COMPENSATION APPEALS BOARD**

Name and Address of Appeals Board: <b>WORKERS' COMPENSATION APPEALS BOARD</b>			
Address	City, State, ZIP Code		
<b>COMPLETED BY:</b>			
Name	Address	City, State, ZIP Code	Telephone No.

Proof of service - special notice of lawsuit

- 1) I served the (check all that apply):
a. ( ) Special notice of lawsuit
( ) Application for adjudication of claim and claim form
( ) Order joining party defendant
( ) Notice of intention
b. ( ) On defendant (name):
( ) Other (name and title or relation to person served):
c. ( ) By delivery: at home ( ) at business ( )
Date:
Time:
Address:
d. ( ) By mailing
Date:
Place:

- 2) Manner of service (check proper box)
a. ( ) Personal service. By personally delivering copies [CCP 415.10]
b. ( ) Substituted service on corporation, unincorporated association (including partnership), or public entity. By leaving, during usual office hours, copies in the office of the person served with the person who apparently was in charge and thereafter mailing (by first-class mail, postage prepaid) copies to the person served at the place where the copies were left [CCP 415.20 (a)]
c. ( ) Substituted service on natural person, minor, conservatee, or candidate. By leaving copies at the dwelling house, usual place of above, or usual place of business of the person served in the presence of a competent member of the household or a person apparently in charge of the office or place of business, at least 18 years of age, who was informed on the general nature of the papers, and thereafter mailing (by first-class mail, postage prepaid) copies to the person served at the place where the copies were left [CCP 415.20 (b)] (Attach separate declaration or affidavit stating acts relied on to establish reasonable diligence in first attempting personal service.)
d. ( ) Mail and acknowledgment service. By mailing (by first-class mail, or airmail, postage prepaid) copies to the person served, together with two copies of the form of notice and acknowledgment and a return envelope, postage prepaid, addressed to the sender. [CCP 415.30] (Attach completed acknowledgment of receipt.)
e. ( ) Certified or registered mail service. By mailing to an address outside California (by first-class mail, postage prepaid, requiring a return receipt) copies to the person served [CCP 415.40] (Attach signed return receipt or other evidence of actual delivery to the person served.)
f. ( ) Other (specify code section):
( ) Additional page is attached.

- 3) The "Notice to the Person Served" (on the notice) was completed as follows [CCP 412.30, 415.0 and 474]:
a. ( ) As an individual defendant
b. ( ) As the person sued under the fictitious name of (specify):
c. ( ) On behalf of (specify):
under:
( ) CCP 416.10 (corporation) ( ) CCP 416.60 (minor)
( ) CCP 416.20 (defunct corporation) ( ) CCP 416.70 (conservatee)
( ) CCP 416.40 (association or partnership) ( ) CCP 416.90 (individual)
( ) California Corporation Code Section 2011 ( ) other:

4) At the time of service I was at least 18 years of age and not a party to this action.

5) Fee for service: \$

- 6) Person serving:
a. ( ) California sheriff, marshal or constable
b. ( ) Registered California process server
c. ( ) Employee or independent contractor of a register California process server
d. ( ) Not a registered California process server
e. ( ) Exempt from registration under Business & Professions Code 22350(b)
f. ( ) Name, address and telephone number, if applicable, county of registration and number:

I declare under penalty of perjury under the laws of the state of California that the foregoing is true and correct.

For California sheriff, marshal or constable use only
I certify that the foregoing is true and correct.

Signature Date

Signature Date

1 State of California  
2 Department of Industrial Relations  
3 Division of Workers' Compensation  
4 **Workers' Compensation Appeals Board**

4 WCAB Case No(s):

5 Applicant

6 vs.

**PETITION TO JOIN PARTY  
DEFENDANT**

7  
8 Defendant(s)

9  
10 Petitioner hereby requests that the following be joined as a party defendant:

11 (Select office nearest your residence)

12 \_\_\_\_\_ Uninsured Employers Fund, 1515 Clay Street, 17<sup>th</sup> Floor, Oakland, CA, 94612

13 \_\_\_\_\_ Uninsured Employers Fund, 2424 Arden Way, Ste. 355, Sacramento, CA, 95825

14 \_\_\_\_\_ Uninsured Employers Fund, 320 West 4<sup>th</sup> Street, 6<sup>th</sup> Floor, Los Angeles, CA, 90013-1105

15  
16 **Proof of Service:**

17 On \_\_\_\_\_ at \_\_\_\_\_  
18 (date) (place)

\_\_\_\_\_  
Petitioner (block letters)

19 Copies mailed to following addressees:

20 1. \_\_\_\_\_

21 2. \_\_\_\_\_

22 3. \_\_\_\_\_

23 **X** \_\_\_\_\_  
(Signature of Petitioner)

24

25

**DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)**

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”

## Ejemplo

### Proof of Service by Mail

I declare that:

I am (resident of/employed in) the county of su condado California. I am over the age of eighteen years, my (business/residence) address is:

la dirección de su residencia

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On fecha de hoy, I served the attached el nombre de la petición o el documento que está enviando por correo on the nombre de los partidos a quién les está enviando la petición o documento in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail at ciudad desde donde está enviando la petición o el documento addressed as follows nombre y dirección de los partidos a quién les está enviando la petición o el documento

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) fecha de hoy, at ciudad California.

Type or print name escriba su nombre en letra de molde

Signature su firma

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of \_\_\_\_\_ California. I am over the age of eighteen years, my (business/residence) address is:

On \_\_\_\_\_, I served the attached \_\_\_\_\_ on the \_\_\_\_\_ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at \_\_\_\_\_ addressed as follows \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) \_\_\_\_\_, at \_\_\_\_\_ California.

Type or print name \_\_\_\_\_

Signature \_\_\_\_\_